PERCEIVED STRESS IN KLEPTOMANIA

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Kleptomania, defined as the recurrent failure to resist the impulse to steal, is associated with significant functional impairment. We hypothesized that people with kleptomania would report elevated levels of perceived stress. Sixteen subjects with DSM-IV kleptomania were administered the Perceived Stress Scale (PSS) and compared with 20 subjects with DSM-IV major depressive disorder (MDD). Change in PSS scores in response to treatment and the relationship between PSS scores and severity of kleptomania symptoms were analyzed. The subjects with kleptomania had a significantly greater mean baseline PSS score than the 20 subjects with MDD (t = 8.55, df = 34, p = .000). PSS scores were significantly correlated with severity of kleptomania symptoms (r = .71, p = .002), even when controlling for comorbid diagnoses (r = .67, p = .006). PSS scores significantly decreased during the course of treatment (t = 9.31, df = 15, p = .000). People with kleptomania have higher levels of perceived stress than people with MDD, and the perceived stress decreases as the kleptomania symptoms are treated.

KEY WORDS: kleptomania; perceived stress; impulse control disorder.

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INTRODUCTION

Kleptomania, defined as the recurrent failure to resist the impulse to steal objects not needed for personal use or their monetary value, was first described almost two centuries ago (1). Although kleptomania is recognized as a distinct psychiatric disorder with a possible prevalence of 0.6% (2), it remains a poorly understood and underrecognized illness. Currently classified by DSM-IV as an impulse-control disorder, kleptomania is defined by three essential features: 1) failure to resist an impulse to steal unneeded objects; 2) an increasing sense of tension or arousal before committing the theft; and 3) an experience of pleasure, gratification or release at the time of committing the theft (3).

People with kleptomania often suffer from comorbid mood, anxiety, substance use, and other impulse control disorders (4–6). Additionally, people with kleptomania suffer the pain and humiliation of repeated arrests, which in turn leads to feelings of guilt, depression and even suicide (1,7). Recent studies have found that kleptomania is associated with significant functional impairment, and high rates of both psychiatric hospitalization and suicidal thoughts (7). Furthermore, clinical observation has suggested that kleptomania may also be associated with high levels of perceived stress. The role of perceived stress in this disorder, however, has not been previously investigated.

Numerous studies have examined the link between stress and illness (8). Some studies have addressed the stress associated with life events (9). Other studies have focused on perceived stress (that is, stress appraised by the individual) (10). Unlike the stress of life events, perceived stress recognizes that individual reactions to the impact of certain life events may vary (11).

People who report high levels of perceived stress tend to view their lives as unpredictable and uncontrollable (12). A number of studies have consistently found an association between severity of depression and perceived stress (11,13). In fact, perceived stress may have a greater correlation with depressive symptoms than negative life events (12,14).

In the present study we examined perceived stress in people suffering from kleptomania. We hypothesized that people with kleptomania would have high levels of perceived stress and that the severity of the perceived stress would be related to the severity of their kleptomania. We also hypothesized that because of the shame and embarrassment associated with kleptomania (7), patients with kleptomania would have higher levels of perceived stress than patients with major depressive disorder.

METHODS

Subjects

Sixteen consecutive subjects with DSM-IV kleptomania were included in a naturalistic prospective study. Whether subjects met DSM-IV criteria for kleptomania was determined by diagnostic interview without the use of a standardized instrument. All 16 subjects were recruited from an outpatient specialty clinic for impulse control disorders. After complete description of the study to the subjects, written informed consent was obtained from all participants. The Institutional Review Board for the University of Minnesota approved of both the study protocol and the consent form.

Assessments

To determine current comorbid psychiatric disorders, each subject was assessed with the Structured Clinical Interview for DSM-IV (SCID) (15). We also administered a semistructured interview to elicit demographic data, lifetime comorbid psychiatric disorders, and information on the phenomenology, age of onset, course, associated features, treatment history and response to treatment of the disorder. Because the SCID covers only certain DSM-IV disorders, a detailed interview assessing a history of impulse control disorders (including impulse control disorders not otherwise specified such as compulsive shopping, psychogenic excoriation, and sexual compulsions) was conducted. Severe personality disorders (e.g. borderline personality disorder, antisocial personality disorder) were assessed by clinical interview.

All kleptomania subjects with comorbid major depressive disorder (N = 6) were administered a Hamilton Depression Rating Scale (HDRS 17-item) (16) at the time of initial evaluation. Subjects with kleptomania were seen monthly for at least six months.

Severity of kleptomania symptoms was assessed with the Kleptomania Symptom Assessment Scale (K-SAS), an eleven-item self-report scale designed to assess the change of kleptomania symptoms during treatment (17). The K-SAS assesses change in urge and thought frequency and duration as well as stealing behavior. The K-SAS has shown good reliability and validity in an initial treatment study (17). Subjects completed the K-SAS at each visit.

All subjects completed the 10-item Perceived Stress Scale (PSS) (14) at initial evaluation and when the K-SAS score was less than or equal to 11 (suggestive of partial or full remission of symptoms) or after 6 months

of treatment. The PSS is a reliable and valid self-report measure designed to assess the degree to which individuals find their lives to be unpredictable, uncontrollable, and stressful. Each statement is answered on a 5-point scale ranging from "never" to "very often" determined by experiences of the previous month. Scores range from 0 to 40.

Subjects with kleptomania were compared with 20 consecutive subjects recruited from a general psychiatry outpatient clinic who were diagnosed with DSM-IV major depressive disorder (MDD) based on the SCID. All subjects with major depressive disorder were administered the HDRS 17-item scale at initial evaluation.

Data Analysis

Baseline scores on the PSS for subjects with kleptomania were compared with MDD subjects using an independent samples t-test. Change in PSS scores between baseline and final treatment visit in subjects with kleptomania were compared using paired t-tests. The relationship between PSS scores and comorbidity was analyzed by one-way ANOVAs. The relationship between PSS scores and severity of kleptomania symptoms (total K-SAS scores) was examined using the Pearson product-moment correlation method. Partial correlation analysis was performed to control for comorbid disorders and to investigate the relationship between PSS and K-SAS scores. Significance was set at p < .05, and all tests were two-tailed.

RESULTS

The 16 subjects with kleptomania (9 females [56%] and 7 males [44%]; mean age = 36.9 years, SD = 10.8) had a significantly greater mean baseline PSS score than the 20 subjects (10 females [50%], 10 males [50%]; mean age = 33.9, SD = 7.7) with MDD (30.0 ± 4.2 compared to 19.2 ± 3.3 ; t = 8.55, df = 34, p = .000). In terms of demographic variables such as age, marital status, and gender, the subjects with kleptomania did not differ significantly from the subjects with MDD. Scores on the HDRS did not differ significantly between those with kleptomania and comorbid major depressive disorder and the subjects with major depressive disorder.

PSS scores at baseline in the kleptomania subjects were significantly correlated with severity of kleptomania symptoms as determined by the baseline K-SAS total score (baseline K-SAS = 32.6 ± 3.7 ; r = .71, p = .002). This correlation was significant even when controlling for comorbid diagnoses (r = .67, p = .006).

A total of 11 of the 16 subjects with kleptomania (68.8%) had a current comorbid diagnosis. The most common current comorbid diagnoses among subjects with kleptomania were major depressive disorder (N = 6, 37.5%) and alcohol abuse (N = 2, 12.5%).

Mean PSS scores did not significantly differ at baseline between kleptomania subjects with or without current comorbid depression (t = -1.68, df = 14, p = .115). The mean baseline PSS scores for kleptomania subjects also did not differ significantly between subjects with zero, one or two comorbid diagnoses (F = 1.6, p = .245). The total number of current comorbid diagnoses was not significantly correlated with PSS scores at baseline (r = .31, p = .248).

All subjects were treated with medication. Seven (43.8%) of the 16 subjects with kleptomania were prescribed naltrexone as monotherapy, 7 (43.8%) were prescribed combination treatment (an SSRI plus naltrexone), and 2 (12.5%) were taking a mood stabilizer. Four of the 16 subjects (25%) were receiving concomitant psychotherapy (cognitive behavioral therapy in all four cases). Nine of the 16 subjects (56.3%) achieved full or partial remission of their kleptomania symptoms (defined as a K-SAS score of 11 or less) during the six-month treatment period.

PSS scores in the subjects with kleptomania significantly decreased during the course of treatment (baseline mean PSS score = 30.0 ± 4.2 ; endpoint mean = 19.1 ± 3.8 ; t = 9.31, df = 15, p = .000). Mean duration of medication treatment until partial or full remission of kleptomania symptoms was 160.9 ± 35.1 days. The change in PSS scores was not significantly correlated with change in K-SAS scores (endpoint mean K-SAS score = 8.4 ± 4.8 ; r = .18, p = .513).

DISCUSSION

The study suggests that people with kleptomania suffer from high levels of perceived stress. As hypothesized, the severity of perceived stress was associated with the severity of kleptomania symptoms. Perceived stress in kleptomania appears to be a function both of the shame that follows each episode of stealing and of the urges associated with the disorder. Because the urges may often have no identifiable trigger, patients with kleptomania live with a constant fear of perhaps being driven to perform behavior that they find reprehensible. The Perceived Stress Scale asks general questions about feeling "out of control," and this is often the phrase that patients use to describe their urges to steal.

The finding that the severity of psychiatric illness correlates with the severity of perceived stress is consistent with the literature examining

depression (11,18). Unlike studies of other psychiatric disorders that have found the presence of comorbid diagnoses to correlate with severity of perceived stress (19), however, the comorbidity of other psychiatric illnesses among these patients with kleptomania did not appear to account for their high levels of perceived stress.

People with kleptomania also appear to have higher levels of perceived stress than people suffering from major depressive disorder. People with kleptomania often suffer intense shame and guilt because of their addictive behavior (17). It is therefore not surprising that the level of perceived stress is greater in these subjects. The presence of current comorbid major depression in some kleptomania patients does not fully account for the relationship between perceived stress and the severity of kleptomania. Because baseline HDRS scores were similar between the two groups, it is therefore less likely that the levels of perceived stress in the subjects with kleptomania is due to more severe depressive symptoms. The kleptomania symptoms appear to be the reason for the greater perceived stress among these subjects.

Our results also demonstrate that treatment of the kleptomania symptoms was associated with a significant decrease in the levels of perceived stress. Patients reported that once the urges to steal were diminished, the feelings of stress were significantly reduced. This finding that symptom reduction results in decreased perceived stress is consistent with the examination of perceived stress in other psychiatric disorders. In the cases of major depressive disorder and body dysmorphic disorder, improvement in the symptoms of the primary psychiatric disorder correlated with a significant decrease in perceived stress (13,19,20).

Although the change in perceived stress appears to be a function of the decrease in severity of kleptomania symptoms, the change in perceived stress scores did not significantly correlate with change in the K-SAS scores. One possible reason for this seemingly inconsistent result is that some subjects who continued to steal may have found stress reduction through the supportive therapy of meeting a psychiatrist on a monthly basis. Thus, some patients would have lower stress scores and yet continue to have higher scores on the K-SAS. Alternatively, once patients experienced some minor kleptomania symptom reduction, other factors that contributed to stress (e.g. guilt, shame, family difficulties) may have normalized to an extent that perceived stress scores decreased even if the stealing behavior continued to some degree.

This study has several limitations. First, a causal relationship between perceived stress and severity of kleptomania cannot be drawn. Does perceived stress contribute to the onset of kleptomania? Does the stealing lead to increased levels of perceived stress? There is simply not enough data available yet to draw any conclusions.

A second limitation is that our sample may not reflect the larger population of patients who suffer from kleptomania. Our sample of subjects with kleptomania voluntarily sought treatment for their disorder in a specialty psychiatric clinic. Some researchers have suggested that most patients with kleptomania do not come forward for treatment (21). The fact that the subjects in this study voluntarily sought treatment may raise the question of whether these patients are "true" kleptomaniacs or are suffering from personality disorders. An unstructured interview did attempt to assess severe personality disorders (borderline personality disorder, antisocial personality disorder), but the lack of a standardized Axis II interview may have resulted in the underdiagnosis of some personality disorders or traits.

Also, recruitment from a specialty clinic for kleptomania may limit the study sample to only those who are really motivated for treatment. What this means, in terms of addictions and human behavioral change, is that our subjects may include only those in the preparation (action) phase or the maintenance/relapse prevention phase, not the denial or precontemplation and contemplation phases (22). Thus, our study sample may not represent all people suffering from kleptomania.

In summary, people with kleptomania have elevated levels of perceived stress that appear to decrease as the kleptomania symptoms are treated. Further studies are needed to confirm these findings.

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